

RECORD OF PROCEEDINGS

IN THE MATTER OF:

DOCKET NUMBER: BC-2024-03723

XXXXXXXXXXXXXXXXXX

COUNSEL: XXXXXXXXXXXX

HEARING REQUESTED: YES

APPLICANT'S REQUEST

His official military personnel records amended to reflect he was continued on active-duty orders for medical continuation (MEDCON) under Title 10, United States Code § 12301(h) [10 USC § 12301(h)] for the period 18 Nov 21 through 17 Aug 24.

APPLICANT'S CONTENTIONS

Per applicant's counsel, on 18 Nov 21, while in inactive drill training status, the applicant received his second COVID vaccination. That evening, he suffered from traumatic subdural hematoma and passed out while in the shower. On 5 Feb 22, while preparing for drill weekend, the applicant noticed stroke-like symptoms and was taken to the emergency room where he was treated for complaints of confusion, headache, and left-sided weakness. The applicant was found to have chronic subdural hematoma with significant midline shift with the fall on 18 Nov 21 believed to have caused the subdural hematoma.

Counsel contended the applicant completed all necessary paperwork for processing a line of duty (LOD) determination on 1 Mar 22 and again in May 22. According to a timeline provided by the applicant's congressional representative, which resulted from a complaint submitted in Sep 22, he had an interim LOD determination on 23 Jun 22. In Aug 22, the applicant requested the status of his LOD determination along with information about MEDCON orders and TRICARE. He was advised his LOD was officially submitted on 22 Jun 24¹ and there was nothing to be done until the LOD was finalized as In the Line of Duty (ILOD). The applicant's congressional response, dated 15 Nov 22, also stated his LOD was considered by the Airman Medical Readiness Optimization (AMRO) Board before it was submitted. Also noted was the National Guard Bureau ordered the applicant's wing to resubmit the LOD determination as a formal investigation, with the wing commander changing his finding to recommend formal investigation in the electronic LOD tracking system. On 4 Nov 22, the applicant treating provider diagnosed him with hyperinflammatory or autoimmune syndrome related to post-COVID vaccination. On 18 Nov 22, the applicant provided his written statement as part of the formal LOD determination. On 10 Jan 23, the applicant's immediate commander found his condition to be ILOD, and on 11 Jan 23, the immediate commander signed the AF Form 348, *Line of Duty Determination*, as the Appointing Authority, reflecting an Investigating Officer was appointed to conduct a formal LOD determination. The DD Form 261, *Report of Investigation Line of Duty and Misconduct Status*, was signed on 7 Feb 23, finding the applicant's condition to be ILOD.

Per counsel, the applicant was advised on 8 Mar 23, that he was not eligible for MEDCON orders at that time but may be eligible once he was entered into the Integrated Disability Evaluation System (IDES). The applicant was informed he may be eligible for incapacitation (INCAP) pay. On 9 Mar 23, the applicant responded with additional questions regarding his

¹ Typographical error; based on timeline should read 22 Jun 22.

eligibility and was advised by the Air Reserve Component Case Management Division (ARC CMD) the MEDCON program adhered to the one-year date-of-injury requirement in accordance with Department of the Air Force Instruction (DAFI) 36-2910, *Line of Duty (LOD) Determination, Medical Continuation (MEDCON), and Incapacitation (INCAP) Pay*, and outside the one year, service members were expected to utilize the Department of Veterans Affairs (DVA) for care and the wing for possible INCAP pay. Counsel further contended ARC CMD advised the MEDCON program only supports service members within the boundaries of DAFI 36-2910 and if the ILOD condition is one-year date-of-injury, an Initial Review in Lieu Of (IRILO) determination/referral to a Medical Evaluation Board (MEB) and enrollment into the DES would be required before a service member can receive MEDCON orders for DES processing.

According to counsel, the applicant's first narrative summary was completed for his IRILO on 10 Mar 23, and his case review and referred into the DES for a full MEB on 10 Aug 23. The MEB recommended the applicant's referral to the informal Physical Evaluation Board (IPEB) on 14 Dec 23 for traumatic subdural hemorrhage. The applicant's narrative summary was updated for DES processing to include neuritis as a potentially unfitting condition. On 6 Mar 24, a new MEB convened considering both conditions and recommended referral to the IPEB. The IPEB found the applicant unfit for continued service due to his subdural hematoma, voiding dysfunction secondary to the hematoma, and diarrhea secondary to the hematoma. The IPEB also found the applicant's bilateral neuralgia and neuritis to not be unfitting at that time. The applicant appealed the findings to the formal PEB (FPEB). On 24 Jul 24, the FPEB recommended the applicant be permanently retired based on his unfitting conditions of subdural hematoma, voiding dysfunction, diarrhea, bilateral neuritis of the lower radicular group, and bilateral neuritis of the external popliteal nerve. The applicant was permanently medically retired under 10 USC § 1201 on 17 Aug 24.

In support of the applicant's request for relief, counsel cited 10 USC § 1074a, 10 USC § 12322, 10 USC § 12301(h), Department of Defense Instruction (DoDI) 1241.01, *Reserve Component (RC) Line of Duty Determination for Medical and Dental Treatments and Incapacitation Pay Entitlements*, Enclosure 3, paragraphs 2.a.(1) and 5.b., DoDI 1332.18, *Disability Evaluation System*, paragraph 1.2.f, and DAFI 36-2910. Counsel also cited case law in support to include *Wilhelmus v. Geren*, 796 F. Supp. 2d 157 (D.D.C. 2011) and *Helferty v. United States*, 113 Fed. Cl. 308, 317 (2013). Finally, counsel provided as precedent Army Board for Correction of Military Records (ABCMR) cases AR20210009764 and AR20240006782, as well as Air Force Board for Correction of Military Records (AFBCMR) cases BC-2022-03094 and BC-2022-00425.

Counsel contended the fact that the applicant incurred an unfitting medical condition while on orders is undisputed. The AF Form 348 and DD Form 261, finalized 15 months after the original injury, acknowledge the injury was incurred ILOD and the applicant's medical retirement on 17 Aug 24 acknowledges his condition was unfitting for continued military service. Equally clear is the federal law that authorizes an injured service member to remain on active-duty orders to obtain medical care and treatment through the completion of the DES, should the condition not improve enough that the service member can be returned to duty. Historically, the BCMR, both Army and Air Force, have granted requests to similarly situated service members when the applicant has shown there was error due to no fault of their own.

Per counsel, the delay in processing the LOD determination was due to no fault of the applicant. While he suffered from a syncopal episode on the evening of his second COVID vaccination, the severity of his condition did not become apparent until 5 Feb 22 when he appeared to be suffering from stroke-like symptoms. Within a month of the applicant's emergency brain surgery on 5 Feb 22, he submitted his LOD determination paperwork required by his unit for processing. The delay in processing the applicant's LOD determination is due to his wing and

the National Guard Bureau (NGB). The timeline of events clearly detailed in the applicant's congressional inquiry response includes a six-week delay for consideration by the AMRO Board prior to submission. This is not an authorized step within DAFI 36-2910. An additional three-month delay was due to NGB rejecting the LOD determination upon receipt. It is unclear why NGB rejected the LOD determination other than they decided a formal investigation needed to be adjudicated instead of an informal investigation. However, nowhere within DAFI 36-2910 is NGB authorized to reject an LOD determination or demand the wing commander change their opinion.

Counsel further contended this manipulation of the system and interjection of actions that are not authorized, resulted in the applicant's LOD official paperwork not aligning with the actual timeline of events. The evidence reflects an ongoing formal LOD investigation occurring in Nov 22; however, the official AF Form 348 was not signed by the Appointing Authority appointing an investigating officer until two months later in Jan 23. The AF Form 348 should have been accomplished through Part V, Block 26, *Appointing Authority*, prior to the initiation of a formal LOD determination. This would include an interim ILOD finding prior to Nov 22 since by that time, a formal LOD investigation was already underway. An interim LOD would have authorized the applicant's MEDCON orders. According to counsel, the processing timeline for an informal LOD determination is 60 workdays. The processing timeline for a formal LOD determination is 160 workdays. From the date the applicant submitted his original LOD paperwork, 1 Mar 22, until the finalized ILOD finding on 7 Feb 23, 235 workdays (344 calendar days) had passed, more than 100 workdays outside of the timeline requirement in DAFI 36-2910 for a formal LOD investigation. Eighty-one workdays of that time were spent with either the wing or NGB engaging in unauthorized processing, to include the AMRO Board review and the informal LOD being returned to the unit for formal LOD processing.

Counsel also contended in addition to the delays in processing the LOD, the Aug 22 communication to the applicant regarding his eligibility for MEDCON not being possible until his ILOD was finalized was a complete misstatement of MEDCON requirements. As of 23 Jun 22, the applicant's unit should have submitted his application for MEDCON. As a result of this unauthorized and unreasonable delay in processing the applicant's LOD determination, he was then denied MEDCON orders in Mar 23 because he was outside one year from the date of his injury. The MEDCON denial on 9 Mar 23 was not a per se incorrect interpretation of DoDI 1241.01. DoDI 1241.01, Enclosure 3, paragraph 4 and its subparagraphs outline when medical care for an ILOD finding terminates. There are four enumerated reasons why medical care authorized under 10 USC § 1074a would be stopped: (1) when the condition has resolved or cannot be materially improved; (2) when the member has been identified for referral into the DES within one year of diagnosis and the member receives a final determination from the PEB; (3) one year has transpired since initial diagnosis and the member has not improved nor been referred into the DES; or (4) the ILOD has been overturned to a Not-ILOD. The MEDCON denial; however, also gives zero credence to the fact that the applicant had zero ability to impact the timeline for his LOD determination and referral into the DES. Furthermore, the timeline of events indicates the applicant had been identified for referral into the DES by the time his ILOD had been returned, and he was inquiring about MEDCON orders in Mar 23. His original narrative summary was signed the day after the communications were received by ARC CMD denying MEDCON, 10 Mar 23.

In closing, counsel contended the applicant was injured ILOD and given his condition, need for continued treatment, and inability to maintain gainful employment due to his condition, he would have remained on active-duty orders had his LOD determination been properly processed in a timely manner. Per counsel, the applicant has been a victim of error and injustice related to his LOD processing, eligibility to remain on 10 USC § 12301(h) orders throughout the completion of his disability case, and eligibility for ongoing medical treatment under 10 USC § 1074a, and the preponderance of the evidence supports granting the applicant's request.

The applicant's complete submission is at Exhibit A.

STATEMENT OF FACTS

The applicant is a retired [State] Air National Guard senior master sergeant (E-8).

On 18 Nov 21, according to ANG Form 105S, *Individual Inactive Duty Authorization/Certification*, provided by the applicant, he performed inactive duty training.

On 30 Nov 21, according to AF Form 348, dated 22 Jun 22, provided by the applicant, he was diagnosed and treated for S06.5X0A – Traumatic subdural hemorrhage without loss of consciousness: subdural hematoma. On 10 Jan 23, the immediate commander recommended a finding of ILOD, and on 11 Jan 23, the Appointing Authority appointed an investigating officer to conduct a formal LOD investigation.

On 17 Feb 22, according to an LOD Information package, provided by the applicant, he initiated an LOD claim.

On 10 Nov 22, according to [State] ANG Director of Staff memorandum in response to congressional inquiry, provided by the applicant, his unit received his LOD package on 5 Mar 22; however, not all medical records were included. On 9 May 22, additional requested medical records were received.

On 26 Sep 22, according to documentation provided by the applicant, the applicant's spouse, on his behalf, submitted a request for congressional assistance regarding his LOD determination processing.

On 15 Nov 22, according to a United States Senate memorandum, provided by the applicant, his representative provided a response to his inquiry, to include a [State] Air National Guard memorandum detailing the timeline of events regarding the processing of the applicant's LOD.

On 7 Feb 23, according to DD Form 261, dated 13 Dec 22, provided by the applicant, his diagnosis of chronic subacute subdural hematoma was found ILOD.

On 10 Mar 23, according to a *Physical Health Template - Medical Evaluation Board Narrative Summary*, provided by the applicant, he was evaluated for a diagnosis of traumatic subdural hemorrhage without loss of consciousness.

On 9 Jan 24, according to a *Physical Health Template - Medical Evaluation Board Narrative Summary*, provided by the applicant, he was evaluated for a diagnosis of traumatic subdural hemorrhage without loss of consciousness and peripheral and cranial nerve injuries with symptoms of persistent neuralgia and neuritis.

On 6 Mar 24, according to AF Form 618, *Medical Board Report*, provided by the applicant, he was diagnosed with:

- Traumatic subdural hemorrhage without loss of consciousness, with approximate date of origin of 5 Feb 22; incurred while entitled to basic pay: Yes; existed prior to service: No; permanently aggravated by service: Yes

- Peripheral and cranial nerve injuries with symptoms of persistent neuralgia and neuritis, with approximate date of origin of 18 Nov 21; incurred while entitled to basic pay: Yes; existed prior to service: No; permanently aggravated by service: Yes

The applicant was referred to the IPEB.

On 26 Jun 24, according to AF Form 356, *Findings and Recommended Disposition of USAF Physical Evaluation Board (Informal)*, provided by the applicant, he was found unfit because of physical disability and was diagnosed with:

- Category I – Unfitting Conditions

- Post-Covid-19 Vaccination complications of Residuals of Traumatic Subdural Hemorrhage as well as Mast Cell Activation Syndrome; DVA rated as subdural hematoma with sequelae of inflammatory diseases status post transient ischemic attack (TIA); Is condition compensable: Yes; Veterans Administration Schedule for Rating Disabilities (VASRD) Code: 8009-8100; Disability Rating: 50 percent; Condition is combat-related as defined in 26 USC § 104: No; Disability was incurred in a combat zone or incurred during the performance of duty in combat-related operations as designated by the Secretary of Defense (NDAA 2008, sec 1646): No; Condition is permanent and stable: Yes.

- Voiding dysfunction secondary to subdural hematoma with migraine with sequelae of inflammatory diseases status post TIA; Is condition compensable: Yes; VASRD Code: 7517; Disability Rating: 20 percent; Condition is combat-related as defined in 26 USC § 104: No; Disability was incurred in a combat zone or incurred during the performance of duty in combat-related operations as designated by the Secretary of Defense (NDAA 2008, sec 1646): No; Condition is permanent and stable: Yes.

- Diarrhea secondary to subdural hematoma with sequelae of inflammatory diseases status post TIA; Is condition compensable: Yes; VASRD Code: 7319; Disability Rating: 0 percent; Condition is combat-related as defined in 26 USC § 104: No; Disability was incurred in a combat zone or incurred during the performance of duty in combat-related operations as designated by the Secretary of Defense (NDAA 2008, sec 1646): No; Condition is permanent and stable: Yes.

- Category II – Conditions That Can Be Unfitting But Are Not Currently Unfitting

- Intermittent Bilateral Leg Symptoms of Neuralgia and Neuritis; VASRD Code: 8621

The IPEB recommended permanent retirement with a combined compensable percentage of 60 percent.

On 24 Jul 24, according to AF Form 356, *Findings and Recommended Disposition of USAF Physical Evaluation Board (Formal)*, provided by the applicant, he was found unfit because of physical disability and was diagnosed with:

- Category I – Unfitting Conditions

- Post-Covid-19 Vaccination complications of Residuals of Traumatic Subdural Hemorrhage as well as Mast Cell Activation Syndrome; DVA rated as subdural hematoma with sequelae of inflammatory diseases status post TIA; Is condition compensable: Yes; VASRD Code: 8009-8100; Disability Rating: 50 percent; Condition is combat-related as defined in 26 USC § 104: No; Disability was incurred in a combat zone or incurred during the performance of duty in combat-related operations as designated by the Secretary of Defense (NDAA 2008, sec 1646): No; Condition is permanent and stable: Yes.

- Voiding dysfunction secondary to subdural hematoma with migraine with sequelae of inflammatory diseases status post TIA; Is condition compensable: Yes; VASRD Code: 7517; Disability Rating: 20 percent; Condition is combat-related as defined in 26 USC § 104: No; Disability was incurred in a combat zone or incurred during the performance of duty in combat-related operations as designated by the Secretary of Defense (NDAA 2008, sec 1646): No; Condition is permanent and stable: Yes.

- Diarrhea secondary to subdural hematoma with sequelae of inflammatory diseases status post TIA; Is condition compensable: Yes; VASRD Code: 7319; Disability Rating: 0 percent; Condition is combat-related as defined in 26 USC § 104: No; Disability was incurred in a combat zone or incurred during the performance of duty in combat-related operations as designated by the Secretary of Defense (NDAA 2008, sec 1646): No; Condition is permanent and stable: Yes.

- Neuritis of the lower radicular group, right upper extremity secondary to subdural hematoma with sequelae of inflammatory disease status post TIA; Is condition compensable: Yes; VASRD Code: 8612; Disability Rating: 40 percent; Condition is combat-related as defined in 26 USC § 104: No; Disability was incurred in a combat zone or incurred during the performance of duty in combat-related operations as designated by the Secretary of Defense (NDAA 2008, sec 1646): No; Condition is permanent and stable: Yes.

- Neuritis of the lower radicular group, left upper extremity secondary to subdural hematoma with sequelae of inflammatory disease status post TIA; Is condition compensable: Yes; VASRD Code: 8612; Disability Rating: 30 percent; Condition is combat-related as defined in 26 USC § 104: No; Disability was incurred in a combat zone or incurred during the performance of duty in combat-related operations as designated by the Secretary of Defense (NDAA 2008, sec 1646): No; Condition is permanent and stable: Yes.

- Neuritis of the external popliteal nerve, right lower extremity secondary to subdural hematoma with sequelae of inflammatory disease status post TIA; Is condition compensable: Yes; VASRD Code: 8621; Disability Rating: 20 percent; Condition is combat-related as defined in 26 USC § 104: No; Disability was incurred in a combat zone or incurred during the performance of duty in combat-related operations as designated by the Secretary of Defense (NDAA 2008, sec 1646): No; Condition is permanent and stable: Yes.

- Neuritis of the external popliteal nerve, left lower extremity secondary to subdural hematoma with sequelae of inflammatory disease status post TIA; Is condition compensable: Yes; VASRD Code: 8621; Disability Rating: 20 percent; Condition is combat-related as defined in 26 USC § 104: No; Disability was incurred in a combat zone or incurred during the performance of duty in combat-related operations as designated by the Secretary of Defense (NDAA 2008, sec 1646): No; Condition is permanent and stable: Yes.

The FPEB recommended permanent retirement with a combined compensable percentage of 90 percent.

On 17 Aug 24, according to Special Order Number XXXX, dated 2 Aug 24, the applicant was relieved from active-duty, organization and station of assignment. Effective 18 Aug 24, he was permanently disability retired with a compensable percentage for physical disability of 90 percent.

APPLICABLE AUTHORITY

DAFI 36-2910, dated 3 Sep 21

Chapter 3 – *Line of Duty Determination Process*

3.2.2.6.3. *Interim LOD (ARC Only)*. The immediate commander may issue an Interim LOD determination to establish initial care and treatment pending a final LOD determination.

3.2.2.6.3.1. An Interim LOD determination should not be made if there is clear and unmistakable evidence showing a EPTS [existed prior to service] condition or clear and convincing evidence that misconduct was the proximate cause of the illness, injury or disease.

3.2.2.6.3.2. The Interim LOD determination is comprised of the completed medical portion of the AF Form 348, which must contain a description of the member's illness, injury or disease, and the date it occurred, as well as the completed immediate commander's portion of AF Form 348, which must contain a preliminary finding of the member's status (Title 10 USC, Title 32 USC, AD, or civilian) at the time the medical condition occurred.

Chapter 6 – *MEDCON for ARC Members*

6.2. *Eligibility*. MEDCON eligibility requires an LOD determination and a finding by a credentialed military medical provider that the member has an unresolved health condition requiring treatment that renders the member unable to meet retention or mobility standards in accordance with DAFMAN 48-123. Members who meet eligibility criteria for MEDCON may with their consent be retained or recalled to duty under 10 USC § 12301, *Reserve Components Generally*, 10 USC § 12322, *Active Duty for Health Care*. (T-0).

6.2.1. Members will be maintained on MEDCON with their consent until:

6.2.1.1. The ILOD injury, illness or disease is satisfactorily resolved or the resulting disability cannot be improved by further treatment or hospitalization; (T-0)

6.2.1.2. The Reserve Component service member is identified for referral to the DES (using the Initial Review in lieu of (IRILO) as the referral into DES), within one year of the initial diagnosis of the condition for which the member received an ILOD finding and the member receives a final determination of fit for duty, separated, or retired; (T-0)

6.2.1.3. One year has transpired since the date of the initial diagnosis and neither actions in paragraph 6.2.1.1 or 6.2.1.2 have occurred; (T-0) or

6.2.1.4. The interim ILOD determination results in a final determination of NILOD Due to Member's Misconduct or NILOD-EPTS-NSA. (T-0).

6.5. *Pre-MEDCON*.

6.5.1. *Purpose*: The purpose of Pre-MEDCON orders of up to 30 days is to allow additional time for ARC members on and, the MTF, RMU or GMU to: 1) ascertain whether the medical condition renders the member unable to perform military duties or unable to meet retention and mobility standards in accordance with DAFMAN 48-123; and 2) provide medical documentation to support a request for MEDCON orders with approval from the member, members' commander (either current commander or reporting commander), the using MAJCOM (who is funding the requirement) and the orders issuing authority. Pre-MEDCON orders cannot be backdated.

6.5.3. Requests can be made to extend Pre-MEDCON orders up to 15 days on a case-by-case basis.

6.6. *Termination of Pre-MEDCON Orders*.

6.6.2. *Discretionary Termination*. Pre-MEDCON orders may be terminated at the discretion of the MAJCOM Functional Area Manager, for the following reasons:

6.6.2.1. The member's failure to fully participate in their prescribed treatment or provide current and sufficient information.

10 USC § 1074a, *Medical and dental care; members on duty other than active duty for a period of more than 30 days*

(a) Under joint regulations prescribed by the administering Secretaries, the following persons are entitled to the benefits described in subsection (b):

(1) Each member of a uniformed service who incurs or aggravates an injury, illness, or disease in the line of duty while performing—

(A) active duty for a period of 30 days or less;

(B) inactive-duty training; or

(C) service on funeral honors duty under section 12503 of this title or section 115 of title 32.

(b) A person described in subsection (a) is entitled to—

(1) the medical and dental care appropriate for the treatment of the injury, illness, or disease of that person until the resulting disability cannot be materially improved by further hospitalization or treatment; and

(2) subsistence during hospitalization.

DoDI 1241.01, dated 19 Apr 16

3. *POLICY*. It is DoD policy that:

a. An RC Service member is entitled to medical and dental treatment for an injury, illness, or disease that was incurred or aggravated while in a qualified duty status and that is not the result of gross negligence or misconduct (referred to in this instruction as a “covered condition”). A determination that establishes a covered condition will be referred to in this instruction as an “in-LOD determination.”

c. The in-LOD determination will be used to authorize appropriate medical and dental treatment for the covered condition for not longer than 1 year from diagnosis without being identified for referral to the DES. An RC Service member will be referred to the DES when the criteria for referral are met in accordance with DoDI 1332.18 (Reference (g)).

Enclosure 3 – *In-LOD Determination for Medical and Dental Treatment*

2. *INITIATION OF IN-LOD DETERMINATION*

a. *Request for in-LOD Determination.*

(1) Unless already initiated by a member’s command, the RC Service member or, if she or he is unable, a designated representative or the Military Service concerned, will initiate the request for an in-LOD determination.

5. *AUTHORITY TO ORDER TO AD FOR MEDICAL AND DENTAL TREATMENT*

b. *AD for Medical and Dental Treatment When on Orders for a Period of 30 Days or Less.* An RC Service member who incurred a covered condition while serving on active duty for a period of 30 days or less may be ordered to, or continued on orders to receive appropriate medical and dental treatment for a covered condition in accordance with section 12322 of Reference (e) if the covered condition occurred while:

(1) Serving on inactive duty training or

(2) Traveling directly to or from such duty.

DoDI 1332.18, dated 10 Nov 22, Section 1 – *General Issuance Information*

1.2. *POLICY.*

f. Pursuant to Section 12301(h) of Title 10, U.S.C., RC Service members may, with the consent of the Service member, be ordered to active duty to receive authorized medical care or to be medically evaluated for disability or other purposes.

Air Force Instruction (AFI) 33-360, *Publications and Forms Management*, dated 1 Dec 15, Chapter 2 – *Roles and Responsibilities*

2.11. *Approving Official*. Approve the release of publications for compliance and enforcement and are solely responsible for ensuring the publications are necessary, current of information, and in conformance with existing laws, policy, guidance and Air Force Mission. Before signing the AF Form 673, it is the responsibility of the approving official to ensure the publication is not less restrictive than higher headquarters publications. If needed, it may be more restrictive, where appropriate.

DAFI 90-160, *Publications and Forms Management*, dated 14 Apr 22

2.10. *Approving Officials*. Approve the release of publications for compliance and enforcement and are solely responsible for ensuring the publications are necessary, contain current information, and conform to existing laws, policy and guidance. Before signing the DAF Form 673, approving officials below the HAF level will ensure the publication is not less restrictive than higher headquarters publications, unless permitted. If needed, the proposed publication may be more restrictive, where appropriate.

Department of the Air Force Manual (DAFMAN) 90-161, Publishing Processes and Procedures

1.4. *Hierarchy of Publications*.

1.4.1. DoD issuances (e.g., directives and instructions) direct actions and assign responsibilities to the SecAF (also known as: Head of DoD component, Secretary of the military department, or Secretary of the Air Force).

1.4.2. The SecAF issues HAFMDs and PDs to delegate authority for implementation in the DAF to the HAF 2-Ltr and L2 officials.

1.4.3. The HAF 2-Ltrs/L2s issue instructions (“what to do”) and manuals (“how to”) to provide detailed guidance and procedures and to further assign responsibilities to 3- or 4-Letter/Level 3 (L3) or Level 4 (L4) offices, MAJCOMs, FLDCOMs, and DAF component commands (USAF/USSF). Subordinate publications would cite the publication that directly disseminates their responsibilities, not the highest-level directives.

AIR FORCE EVALUATION

AFPC/DPFA recommends partially granting the applicant’s request with MEDCON orders from 9 May 22 through 17 Aug 24. Based on the documentation provided by the applicant and analysis of the facts, there is evidence of an error/injustice. The delay in processing his LOD and the improper counseling regarding his MEDCON eligibility at the local level likely contributed to the applicant being denied MEDCON benefits.

The applicant would have met the specified criteria in accordance with DAFI 36-2910:

(1) A copy of the applicant’s orders covering the period during which the injury, illness, or disease was incurred or aggravated; (Met). The member was administered the COVID vaccine while on Inactive Duty Training (IDT) orders after which (that evening) he sustained a syncopal event. The IDT order is included.

(2) An interim or finalized LOD (AF Form 348 or DD Form 261); (Partially Met). The exact timeline is difficult to ascertain since the signature dates on the AF Form 348 appear to have been applied (overwritten) following the lengthy formal investigation. However, based on information contained within this AFBCMR package, the applicant submitted all requested

documentation on 9 May 22. After a delay in which the local medical group reviewed the LOD at the AMRO Board, the decision was made to submit the LOD on 23 Jun 22 from the wing commander. AN LOD is considered “interim” and can be utilized to authorize MEDCON as soon as the immediate commander signs it. Presumably, this LOD would have been signed by the immediate commander originally between 9 May 22 and 23 Jun 22. Therefore, 9 May 22 can be considered the earliest possible date on which to base MEDCON eligibility.

(3) A completed AF Form 469, *Duty Limiting Condition Report*; (Partially Met). Unfortunately, the AF Form 469 was not included with this application package, and because the applicant has been medically retired, the profile history is no longer maintained in Aeromedical Services Information Management System. The applicant did not initially present to the emergency department immediately following his injury on 18 Nov 21. He also did not report the injury to his local medical group within the required timeframe. This likely contributed to a delay in initiating his LOD as the local medical group had to await supporting documents. Based on available documentation, the local medical group became aware of the applicant’s condition following his 5 Feb 22 hospital admission. Given the severity, it is reasonable to assume his profile began on or about this date.

(4) A medical evaluation conducted by a credential military provider within the last 30 days that describes why the applicant is unable to meet retention or mobility standards, citing a specific paragraph from Chapter 5 or 13 of AFI 48-123²; (Partially Met). See above discussion.

(5) An individual treatment plan approved by a credentialed military provider based on occupational medicine guidelines and peer-reviewed recovery timelines that includes the expected duration of the impairment; (Partially Met). Beginning on 5 Feb 22, the applicant was actively engaged in evaluation and treatment of various post-vaccination complications including subdural hemorrhage, mast cell activation syndrome (MCAS), and neuritis. The above timeline reflects appointments documented in the AFBCMR package. There are a number of follow-up visits and radiology/procedure visits that are not listed.

Although the applicant has a single LOD for subdural hemorrhage, he was ultimately determined by the FPEB to be unfit for post-COVID-19 vaccination complication residuals of traumatic subdural hemorrhage, MCAS, and neuritis. The FPEB recommended permanent retirement with a disability rating of 90 percent. For MEDCON purposes, the LOD should be presumed to include all post-COVID vaccination complication residuals acknowledged by both the MEB and FPEB.

While on IDT orders, the applicant underwent a mandated COVID immunization on 18 Nov 21. That evening, he passed out in the shower leading to an unrecognized head injury. His condition slowly deteriorated, culminating in hospitalization and surgery for a chronic subdural hemorrhage on 5 Feb 22. After the applicant reported his condition, it appears the LOD initiation was further delayed at the local level. Contributing factors included the applicant’s decision not to seek immediate treatment, delayed reporting of the injury, lack of understanding of the underlying disease process, and decision to convene an AMRO Board. The AMRO Board review is not part of the LOD process. Also, the guidance provided by the local medical group’s medical technician that a finalized LOD was required to apply for MEDCON was incorrect. The record shows the applicant submitted all required documentation for initiation of his LOD on 9 May 22. It should also be pointed out the finalization of this LOD was further delayed by the formal investigation directed by the Air Reserve Component LOD Determination board. It required approximately nine months beyond the report date for signature by the Approving

² Guidance in effect at the time of MEDCON processing was Department of the Air Force Manual 48-123, *Medical Examination and Standards*, dated 8 Dec 20, Chapters 4 and 5.

Authority on 7 Feb 23. Based on the fact that the IRILO proceeded promptly thereafter, it should be concluded the timeline for entry into the DES was also impacted by the delay.

Once the applicant's LOD was initiated, he almost certainly would have met all MEDCON eligibility criteria. There is a reference in his MEB narrative summary that the applicant was on profile without additional details. Still, it can be assumed the applicant would not have met mobility requirements following his surgery. Additionally, the medical evaluation and care being provided for the applicant for post-vaccination complications are significant and extended from his presentation on 5 Feb 22 through his entry into the DES on 10 Aug 23. He met MEDCON eligibility requirements as soon as his LOD was considered interim and would then have been entitled to remain on MEDCON orders for the duration of his DES processing.

Regarding DoDI 1241.01, Enclosure 3.c., which states that the ILOD determination will be used to authorize medical treatment for no longer than one year from diagnosis without being identified for referral to the DES, it is clear the delay in initiating and finalizing the LOD delayed the applicant's entry into the DES. Had the LOD been processed in a timely manner, he would have been on MEDCON and referred to the DES within one year of initial diagnosis.

The complete advisory opinion is at Exhibit C.

APPLICANT'S REVIEW OF AIR FORCE EVALUATION

The Board sent a copy of the advisory opinion to the applicant on 27 May 25 for comment (Exhibit D), and the applicant replied on 24 Jun 25. In her response, counsel, on behalf of the applicant, contended the general principle of the hierarchy of laws is that where there is a disagreement between a higher-level of authority and a lower-level authority, the higher-level authority governs, unless an express exception has been given and noted in the lower-level authority. Congress can delegate its authority to the Secretary of Defense and the Secretary of Defense can delegate authority down to the Service Secretaries. From there, the Service Secretaries may delegate authority within the service if it is not expressly prohibited. The advisory opinion cited specified criteria in accordance with DAFI 36-2910 that must be met before a service member qualifies for MEDCON. However, the authority to establish criteria to qualify for MEDCON had not been delegated down to the Service Secretaries. 10 USC § 1074a is the provision of the USC that establishes the right for medical care for service members who were injured while ILOD during a period of orders for 30 days or less. 10 USC § 12322 provides the authorization for active-duty orders for a period of more than 30 days while the service member is receiving treatment for the ILOD injury. Finally, 10 USC § 12301(h) provides "when authorized by the Secretary of Defense, the Secretary of a military department may, with the consent of the member, order a member of a reserve component to active duty— (A) to receive authorized medical care..." DoDI 1241.01 implements these provisions of the USC, establishing the standards for determining when a condition is ILOD as well as providing the DoD policy regarding 10 USC § 12301(h) MEDCON orders. While Enclosure 2, paragraph 6.a. authorizes the Service Secretaries to "issue regulations, funding policies, and procedures to implement this instruction" it does not provide the Service Secretaries discretion to establish criteria to qualify for MEDCON orders. Enclosure 3, paragraph 5.b. specifically states that a service member is allowed to be placed on active-duty orders for medical care for an injury incurred in the line of duty in accordance with 10 USC §12322.

It is important to note the difference in wording between DoDI 1241.01, paragraph 5.a. and paragraph 5.b. Paragraph 5.a. does provide discretion to the Service Secretaries to order a service member to active duty for medical evaluation and other purposes. The Plain Writing Act of 2010, as implemented in DoDI 5025.13, *DoD Plain Language Program*, requires the government to be clear, concise, and specific with its choice of words. DoDI 1241.01 provides a distinction between the two paragraphs and the congressionally-mandated benefits authorized

depending on the circumstances of the request for active-duty orders. The distinction being that of an ILOD condition that requires further treatment (paragraph 5.b.) versus a need for a medical evaluation or other purposes (paragraph 5.a.). The Secretary of Defense has not authorized the Air Force to establish additional criteria for MEDCON orders if the service member meets the statutory requirements for MEDCON orders under 10 USC § 1074a and 10 USC § 12322. The statutory requirements for MEDCON entitlements are: (1) an ILOD condition, (2) the request to be brought onto active-duty orders for medical care by the service member, and (3) a continued need for medical care. Counsel refers to AFBCMR case BC-2019-02098-2 in support of this contention. While 10 USC § 12322 and 10 USC § 12301(h) both use the word “may” in the statutory text, the Federal Courts have routinely recognized that when used in this context the term “may” is nondiscretionary (*See Kelly v. U.S.*, 69 F.4th 887, Fed. Cir. 2023, internal citations omitted). The “may” utilized by Congress appears to mean at the request of the service member, not at the discretion of the Service Secretaries. If a service member meets the statutory criteria to qualify for MEDCON, the Air Force cannot impose additional restrictions on that entitlement or deny a service member those congressionally-mandated benefits.

The advisory opinion lists five criteria established within DAFI 36-2910 that the applicant would have to meet prior to being authorized MEDCON: (1) a copy of the orders covering the period of injury; (2) an interim or finalized ILOD determination; (3) a completed AF Form 469 profile; (4) a medical evaluation conducted by a credentialed military provider within 30 days explaining why the member cannot meet medical retention standards; and (5) an individual treatment plan approved by a credentialed military medical provider based on occupational guidelines and peer reviewed recovery timelines that includes the expected duration of the impairment. DoDI 1241.01, Enclosure 2, paragraph 6.d. requires the Service Secretaries to “[d]evelop and maintain a plan to case manage RC Service members with an in-LOD determination while being treated in an MTF or with SHCP. Case management will ensure an RC Service member receives proper treatment, evaluation, benefit counseling, and referral services.” However, this paragraph requires oversight after the service member is receiving treatment under an ILOD finding, not as a precursor to receiving orders and treatment. None of the criteria listed in DAFI 36-2910 and cited by the advisory opinion are required or authorized by Congress or the Secretary of Defense, other than an ILOD finding before MEDCON is granted.

A quick analysis of the five criteria is provided to show how the Air Force has overstepped its bounds and is imposing unnecessary burdens on injured service members before they can obtain necessary medical care. First is the requirement to provide orders that encompass the injury. This requirement is in addition to the second criterion which is to provide an ILOD determination (interim or final). A review of DoDI 1241.01, Enclosure 3, paragraph 3.b.(1) requires the final approval authority to ensure the service member was in a qualified duty status at the time of injury. DAF Form 348 also requires confirmation of a qualified duty status as a part of processing. These two criteria are duplicative and, while not a huge burden on the service members, unnecessary given the requirements for LOD processing. Criterion 2 is also problematic because the Air Force’s definition of an interim ILOD finding does not align with that established within DoDI 1241.01.

Criterion 3, the need for a profile, is not required by USC, but more importantly, is not something within the control of the service member, which can and does result in delays in processing at no fault of the service member. Only military medical providers have access to grant a profile; a service member can request one, but it does not have to be granted. There is no right to appeal a denial of a profile. Finally, the service member has no ability to see what conditions are being used to create the profile. All of this provides additional unnecessary burdens on an injured service member whose sole focus should be on treatment.

Criterion 4, the requirement to have a military medical provider find the service member does not meet medical retention standards, is by far the most subjective and unduly burdensome

requirement placed on the service member. This not only requires the service member be able to be seen by a credentialed military medical provider within 30 days, but that the member have a condition that does not meet retention standards. DoDI 6130.03v2, *Medical Standards for Military Service: Retention*, establishes the criteria for medical retention standards. A significant number of conditions contained within that regulation require significant treatment without marked improvement before the condition becomes disqualifying, not only providing a very broad scope of what meets criteria but allowing the individual military provider incredible amounts of discretion to determine if a service member meets or does not meet standards. Most importantly, as it pertains to the congressional requirements for MEDCON orders is that whether a service member meets retention criteria only matters when it comes to the termination of their MEDCON orders after one year has transpired since the date of original injury. If, at that time, the service member has not been referred into the DES, then MEDCON orders must be terminated in accordance with DoDI 1241.01, Enclosure 3, paragraph 4.a.

Finally, there is no statutory requirement for a treatment plan, other than the oversight required under DoDI 1241.01 after the service member is on orders and receiving treatment. In case BC-2022-00391, ARC CMD recommended denying the request for backdated MEDCON orders due to the inability of the member to be evaluated by either physical therapy or orthopedics. The Board disagreed with this recommendation finding the applicant had been receiving medical care the entire time and the delays were due to no fault of the member. This case highlights the real-world complications with imposing such restrictive (and illegal) criterion before granting MEDCON orders. It is incredibly difficult for individuals to obtain the necessary evaluations and care to support a treatment plan due to availability, or lack thereof, to get necessary appointments effectively overnight, especially with specialty areas such as orthopedics or physical therapy. Reserve component members who receive care from civilian providers face an additional hurdle to obtain a treatment plan from a non-treating military medical provider that satisfies this arbitrary criterion. Counsel cited BC-2022-03094 in support of this contention.

Counsel cited an excerpt from DoDI 1241.01, Enclosure 3, paragraph 2.b, contending DAFI 36-2910 does not account for this provision authorizing an interim ILOD for emergent and immediate follow up care. DAFI 36-2910, paragraph 1.3.7. states a reserve component member is authorized for emergency medical treatment at an MTF and an LOD determination must occur after the emergency has stabilized. Under DAFI 36-2910, paragraph 3.2.2.6.3, an immediate commander is allowed to issue an interim ILOD finding; however, DAFI 36-2910 authorizes the commander to deny it “if there is clear and unmistakable evidence showing a EPTS condition or clear and convincing evidence that misconduct was the proximate cause of the illness, injury, or disease.” Both requirements within DAFI 36-2910, paragraph 3.2.2.6.3 are outside the scope of what is allowable under DoDI 1241.01. Clear and unmistakable evidence of misconduct is a significantly higher legal burden of proof to deny an interim ILOD under DoDI 1241.01 than that stated in DAFI 36-2910. Additionally, DoDI 1241.01 does not contemplate denying an interim ILOD finding for emergency treatment for an EPTS condition. Treatment is authorized unless it is undebatable that the condition was due to misconduct by the member. This lessening of the burden for the government within DAFI 36-2910 is illegal and unenforceable. Finally, DAFI 36-2910 provides a significantly greater timeline for accomplishing what the Air Force considers an interim ILOD finding than that established by DoDI 1241.01, allowing for 45 workdays from request by the service member to completion by the immediate commander. Given the service member is authorized up to 180 days after completion of the qualified duty status, the maximum number of days for processing of an interim LOD under DAFI 36-2910 could be 215 calendar days versus the 30 days required by DoDI 1241.01.

Contrary to the assertions by the advisory opinion, on 18 Nov 21, the applicant required and sought emergent treatment for his syncopal episode after receiving the COVID-19 vaccination earlier that day. While he did not go to the hospital that evening, at the time the paramedics left his residence it was noted his vital signs were within normal ranges and the applicant was feeling

better. It was over the next couple of months that the applicant's condition continued to deteriorate that led to the 5 Feb 22 discovery of the subdural hematoma resulting from COVID-19 vaccination and syncope episode in Nov 21. The advisory opinion is unclear in its assertions which injury it is referencing when stating the applicant did not report the injury to his local medical group within the required timeframe. Whether the advisory opinion was referring to the 18 Nov 21 injury or the 5 Feb 22 discovery of the subdural hematoma, this statement represents a clear misunderstanding of the requirements of DoDI 1241.01. DoDI 1241.01, Enclosure 3, paragraph 2.a.(2) grants reserve component service members up to 180 days after completion of the qualified duty status to request consideration for an in-LOD determination absent special circumstances. On 5 Feb 22, the applicant had emergency brain surgery. He spent five days in the hospital recovering from surgery. Within five days of being released from the hospital (12 days post-brain surgery) the applicant submitted his original LOD package to his unit. This submission was well within the timeframe established by the DoD for requesting an LOD.

According to DoDI 1241.01, the applicant should have been issued an interim ILOD finding on 18 Nov 21, or at the latest 5 Feb 22, to authorize him emergent treatment due to an ILOD condition that was not due to his own misconduct, and then another interim ILOD within 30 days after coming off orders to continue treatment. While the advisory opinion does acknowledge the applicant's LOD was delayed in processing at the local level due to no fault of the applicant, it fails to address the requirements under DoDI 1241.01 for an immediate interim ILOD finding followed by an additional one issued within 30-days of termination of qualified duty status orders. DAFI 36-2910, paragraph 6.5.1.1., does contemplate the need for continued orders while an LOD is processing in the form of pre-MEDCON orders. No discussion was made by the advisory opinion regarding this authorization and semi-compliance with the requirements of DoDI 1241.01 for an interim ILOD. The applicant should have been placed on pre-MEDCON orders for at least 30 days while his LOD was being completed.

While none of the statutes clearly state when the entitlement to medical care and active-duty orders begins, common sense dictates it would start from the date of incurrence or aggravation of the injury. Here the advisory opinion recommends MEDCON should only be backdated until the earliest possible date the commander could have signed the interim ILOD; in this case 9 May 22. This date fails to account for AFBCMR case precedent on similar matters, but also for the requirements for an interim ILOD as outlined above. The AFBCMR is bound by its precedent in similarly situated cases. Counsel cited excerpts from BC-2023-02287, BC-2022-00391, and BC-2022-01575 in support.

The recommendation from the advisory opinion in the applicant's case does not align with law, regulation, or common sense. The advisory opinion acknowledged the "medical evaluation and care being provided for this member for post-vaccination complications are significant and extended from his presentation on 5 Feb 22 through his entry into the DES on 10 Aug 23." But then the advisory opinion goes on to recommend denial of MEDCON orders from the period between 5 Feb 22 and 9 May 22 with no valid legal justification. Per counsel, the applicant is entitled to MEDCON orders dating back to his original injury on 18 Nov 21.

The applicant's complete response is at Exhibit E.

FINDINGS AND CONCLUSION

1. The application was timely filed.
2. The applicant exhausted all available non-judicial relief before applying to the Board.
3. After reviewing all Exhibits, to include the applicant's rebuttal, the Board concludes the applicant is the victim of an error or injustice. The Board concurs with the rationale and

recommendation of AFPC/DPFA, in part, and finds a preponderance of the evidence substantiates the applicant's contentions. Specifically, the applicant has provided evidence of his timely submission of LOD documentation, to include supporting medical records, as well as documentation reflecting the applicant was miscounseled on his MEDCON eligibility. Additionally, there is evidence the applicant's LOD determination was delayed through no fault of his own, impacting the processing of his MEDCON request, which is sufficient to justify granting the applicant's request to be placed on MEDCON orders in accordance with 10 USC § 12301(h) for the period beginning the initial date of the ILOD conditions and during which the applicant met all three criteria required for MEDCON.

Furthermore, counsel's contention regarding DAFI 36-2910 being contrary to law and DoD guidance is unfounded. The USC and DoD guidance authorizes the Air Force to place reserve component members on active-duty orders to receive medical care. In accordance with AFI 33-360, DAFI 90-160, and DAFMAN 90-161, the DAF-level instruction implementing this broader guidance is permitted specific, more restrictive processes and requirements that are not necessarily found in that higher-level guidance.

Additionally, the Board found despite counsel's selective citation of previous AFBCMR cases in support of her contentions, the referenced AFBCMR cases actually support the recommendation provided by the advisory opinion in this case. The current advisory opinion's reliance on processes for determining MEDCON eligibility established by DAFI 36-2910 is also found in the advisory opinions provided for the cited cases, confirming the AFBCMR followed its own precedent and adjudicated similarly situated cases comparably within the context of their unique circumstances.

Finally, the Board found the advisory opinion, in its recommendation, considered the delayed processing of the applicant's LOD when establishing a start date for MEDCON eligibility, extending consideration while remaining within the eligibility criteria mandated by DAFI 36-2910; however, this Board finds the applicant's medical records support utilizing the date of initial injury as the MEDCON start date as he was pursuing evaluation and treatment for his ILOD condition. Therefore, the Board recommends correcting the applicant's records as indicated below.

4. The applicant has not shown a personal appearance, with or without counsel, would materially add to the Board's understanding of the issues involved.

RECOMMENDATION

The pertinent military records of the Department of the Air Force relating to APPLICANT be corrected to show he was continued on active-duty, for the purpose of medical continuation in accordance with 10 USC §12301(h), for the period 18 Nov 21 through 17 Aug 24, with full pay, allowances, and benefits.

CERTIFICATION

The following quorum of the Board, as defined in DAFI 36-2603, *Air Force Board for Correction of Military Records (AFBCMR)*, paragraph 2.1, considered Docket Number BC-2024-03723 in Executive Session on 18 Jul 25:

, Panel Chair
, Panel Member
, Panel Member

All members voted to correct the record. The panel considered the following:

- Exhibit A: Application, DD Form 149, w/atchs, dated 16 Oct 24.
- Exhibit B: Documentary evidence, including relevant excerpts from official records.
- Exhibit C: Advisory opinion, AFPC/DPFA, dated 22 May 25.
- Exhibit D: Notification of advisory, SAF/MRBC to Counsel, dated 27 May 25.
- Exhibit E: Applicant's response to advisory, w/atchs, dated 24 Jun 25.

Taken together with all Exhibits, this document constitutes the true and complete Record of Proceedings, as required by DAFI 36-2603, paragraph 4.12.9.

X

Board Operations Manager, AFBCMR